Supreme Court, U. S.
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IN THE

Supreme Court of the United States

October Term, 1975.

No. 75-1691.

PAUL I. GUEST, President of Methodist Hospital, CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of St. Joseph's Hospital, METHODIST HOSPITAL, and DELAWARE VALLEY HOSPITAL COUNCIL, on Behalf of Themselves and All Others Similarly Situated,

Appellants,

v.

F. EMMETT FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in Their Official Capacities, THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA, and BLUE CROSS OF GREATER PHILADELPHIA,

Appellees.

On Appeal From the United States District Court for the Eastern District of Pennsylvania.

BRIEF FOR APPELLANTS.

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PAUL I. GUEST, et al.,

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F. EMMETT FITZPATRICK, JR., et al.,

Appellees.

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA.

—

BRIEF FOR APPELLANTS.

—

OPINION BELOW.

The majority and dissenting opinions of the United States District Court for the Eastern District of Pennsylvania are reported at 409 F. Supp. 818. Copies of the opinions are appended to the Jurisdictional Statement at J. S. App. A5-A23 and J. S. App. A26-A32.[1]

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1. References to "J. S. App. A—" are to pages of the Appendices to the Jurisdictional Statement. References to "A. —" are to pages of the printed Appendix.

JURISDICTION.

The decision and final order of the three-judge court were entered on March 2, 1976 (J. S. App. A24-A25) and notice of this appeal was filed in the United States District Court for the Eastern District of Pennsylvania on March 22, 1976 (J. S. App. A34). Probable jurisdiction was noted on October 4, 1976.

The jurisdiction of this Court is invoked under 28 U. S. C. § 1253, this appeal having been taken from an order denying, after notice and hearing, a permanent injunction in a civil action required by Act of Congress (28 U. S. C. § 2281) to be heard and determined by a district court of three judges.

CONSTITUTIONAL PROVISIONS AND STATUTE INVOLVED.

The Contract Clause of the Constitution of the United States, Article 1, Section 10, provides:

> "No State shall . . . pass any . . . Law impairing the Obligation of Contracts . . . ."

The Due Process Clause of the Constitution of the United States, Amendment 14, Section 1, provides:

> ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law . . . ."

The Statute Involved, Act 94 of the 1975 Session of the Pennsylvania Legislature (Act of August 2, 1975, P. L. 293, amending Section 6124 of Title 40 of the Pennsylvania Consolidated Statutes), is reproduced in the Addendum to this Brief.

QUESTIONS PRESENTED.

1. Do not the Due Process and Contract Clauses prohibit retroactive state legislation which effects a substantial impairment of vested contract rights and a taking of property without just compensation, even though the state purports to have so legislated in accordance with its view of the public welfare?

2. Assuming *arguendo* that legislation which, on its face, reinstates and extends private contracts may be treated as the legal equivalent of rate regulation, does not the Constitution protect private, non-profit hospitals from being compelled to render service at rates which do not permit them to recover their full historic costs of doing business?

3. Absent any state hearing procedure through which the hospitals could protest their being obliged to provide service at non-compensatory rates, was not the district court at least obliged to grant the hospitals a hearing on their allegation that the rates under which Act 94 compels them to provide service are confiscatory?

STATEMENT OF THE CASE.

This class action was brought by 37 hospitals in the Philadelphia area (the "Delaware Valley Hospitals") and certain of their executive officers, administrators and employees on behalf of themselves and all others similarly situated. Seeking declaratory and injunctive relief, plaintiffs challenged the constitutionality of an act of the Pennsylvania legislature ("Act 94") which reinstated a terminated contract between the Delaware Valley Hospitals and Blue Cross of Greater Philadelphia ("Blue Cross") and imposed statutory restraints on the rights of hospitals to terminate contracts with hospital plan corporations like Blue Cross.[2] The case was heard by a three-judge court, as required by 28 U. S. C. § 2284, upon cross motions for summary judgment. This appeal is taken from the order of that court, with one judge dissenting, upholding the constitutionality of Act 94, denying the requested injunction, and granting summary judgment to the defendants.

Act 94 (approved August 2, 1975 and effective immediately upon approval) amended Chapter 61 of Title 40 of the Pennsylvania Consolidated Statutes. Chapter 61 provides for the certification and regulation by the Pennsylvania Insurance Department of hospital plan corporations authorized to establish, maintain and operate plans whereby subscribers to the plans will be provided prepaid hospitalization or related health benefits.

Blue Cross is a hospital plan corporation certified under Chapter 61. Under its contracts with subscribers ("subscriber contracts"), Blue Cross agrees to provide one of two different kinds of benefits depending upon whether the hospital from which the subscriber receives services

2. Named as defendants were Blue Cross, F. Emmett Fitzpatrick, Jr. (District Attorney of Philadelphia), Robert P. Kane (Attorney General of the Commonwealth of Pennsylvania) and the Insurance Department of the Commonwealth of Pennsylvania, each of whom has responsibility for the enforcement of Act 94.

has become a "member hospital," that is to say a hospital which has entered into a second kind of contract (a "membership contract") with Blue Cross. In cases where the subscriber obtains services from a "member hospital" Blue Cross will pay the hospital directly for the services furnished the subscriber in accordance with the payment formula contained in the membership contract between the hospital and Blue Cross. A member hospital agrees to accept payment under the terms of its membership contract with Blue Cross and gives up the right to obtain payment from its Blue Cross subscriber-patients except to the extent that individual subscriber contracts may require the subscriber to pay a small portion of the hospital bill as "co-payment" (Affidavit of Bruce Taylor, President of Blue Cross, ¶¶ 7, 10; A. 79, 80-1).

Alternatively, where a subscriber is admitted to a hospital which is not a member hospital, *i.e.*, a hospital which does not have a currently effective contract with Blue Cross, the subscriber-patient remains liable to the hospital for the normal charges of his or her hospitalization and treatment and is entitled to receive from Blue Cross only what is called an "indemnity benefit." Typically, the Blue Cross indemnity payment will be much less than the amount of payment called for under the usual membership contract, and accordingly less than full hospital charges (Affidavit of Bruce Taylor, ¶ 20; A. 83-4).

Act 94 was enacted as a legislative response to a particular factual situation involving the membership contract between Blue Cross and the Delaware Valley Hospitals (the "Delaware Valley Agreement").

Contractual Background.

On July 1, 1971, the Delaware Valley Hospitals acting through a common bargaining agent, the Delaware

Valley Hospital Council ("DVHC"), negotiated a two year membership contract with Blue Cross (Exhibit 17; A. 147a-262a), which provided for payment according to what Blue Cross denominates as a "reasonable cost reimbursement" formula. Under this formula, the Delaware Valley Hospitals were reimbursed the specifically identified costs of services rendered individual Blue Cross subscribers, but were not reimbursed for any part of certain other traditionally accepted costs of operating a hospital. These are costs which are not identified to particular paying patients, but costs which must be recovered nonetheless from total patient revenues if non-profit hospitals such as appellants are to maintain a balanced operating budget (Affidavit of Edward J. Armstrong, ¶ 4; A. 71-2, and Supplemental Affidavit of Joseph A. Williamson, ¶ 17; A. 117-18).

Foremost among the costs incurred by the hospitals but not recognized by the Blue Cross "reasonable cost reimbursement" formula are costs associated with unreimbursed patient care. This includes the cost of providing care to indigents and the cost of services provided non-indigents for which the hospitals are unable to collect charges. A substantial portion of the latter expense stems from bad debts of patients who enter the hospitals as Blue Cross subscribers and then exhaust coverage before they are discharged (Supplemental Affidavit of Joseph A. Williamson, ¶¶ 3, 4; A. 112-13). In accordance with sound fiscal policy, these costs are normally allocated and billed by the hospitals on a pro rata basis to all private paying patients (Affidavit of Edward J. Armstrong, ¶ 3; A. 71).

In order to make up for the losses produced by the exclusion of these expenses from the "reasonable costs" recognized by the Blue Cross payment formula, the prior membership contract between Blue Cross and DVHC, dated July 1, 1967, had included what was called a "plus factor"—an additional unrestricted grant by Blue Cross to

the hospitals over and above cost reimbursement (Supplemental Affidavit of Paul I. Guest, ¶ 4; A. 103-05). However, the 1971 contract contained no "plus factor" and, indeed, no mechanism to permit the hospitals to recoup losses represented by the difference between the amount of charges allocable to Blue Cross subscriber-patients and the amount of reimbursement actually paid by Blue Cross. This problem was further exacerbated by the fact that the 1971 contract (Section 18.4.1) contained a ceiling limitation on Blue Cross payments in terms of a stated percentage of the prior year's costs (A. 171a).

Appellants are non-profit hospitals which have no profit margin within which to absorb the costs of "discounted" payments from Blue Cross (Affidavit of Edward J. Armstrong, ¶¶ 4, 9; A. 71-2, 73). Thus, the amount of these Blue Cross underpayments necessarily resulted in net operating losses, whether they were recognized immediately or simply pushed forward to some future date by borrowing against reserves set up for replacement of fully depreciated facilities and equipment.[3] There was no Dela-

3. There are only a limited number of sources from which a non-profit hospital may recover the operating expenses which Blue Cross refuses to pay. Some part may be surcharged to those private patients who are self-insured or covered by commercial insurers. While in most cases it is not possible to impose the entire burden on this relatively small segment of the patient population, the need to reduce losses by surcharging private paying patients has resulted in situations in which, in extreme cases where private patients are relatively few in number, private insurers have paid full charges as much as 40% more than the amounts paid by Blue Cross for comparable services rendered its subscribers (Supplemental Affidavit of Joseph A. Williamson, ¶ 7; A. 114).

To the extent that the pool of private paying patients is too small to make up the total deficiencies in Blue Cross payments (and, as the burden of these deficiencies on the private paying patients becomes greater, more members of this group who are able to do so are under pressure to become Blue Cross subscribers, thus shrinking the size of the private patient pool and increasing accord-

ware Valley Hospital which did not suffer a loss under the 1971 Agreement. The amount of loss varied from a low of $50,000 per year in the case of Jeanes Hospital through $203,400 reported by Presbyterian-University of Pennsylvania Medical Center to more than $655,000 reported by Mercy Catholic Medical Center for fiscal year 1974 (Affidavit of Edward J. Armstrong, ¶ 10; A. 73; Supplemental Affidavit of Joseph A. Williamson, ¶ 6; A. 113-14).

Despite the Delaware Valley Hospitals' dissatisfaction with the reimbursement formula, the 1971 contract, which was terminable upon 90 days' notice and should have expired by its terms on July 1, 1972, was continued for an extended period of futile negotiations before it was finally permitted to terminate on March 31, 1974.

The Delaware Valley Agreement contained a ceiling limitation on Blue Cross payments for the first contract year only, providing further that unless new payment terms could be negotiated six months prior to the end of the first year, the contract would terminate as of July 1, 1972. However, although no new contract terms had been negotiated, when, on July 1, 1972, federal price controls

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3. (Cont'd.)

ingly the burden on each member), the hospitals must reduce their net operating loss from non-operating income sources. Thus, they use unrestricted endowment fund income where available and, in at least one case, endowment fund principal to the extent permitted by law (Supplement Affidavit of Joseph A. Williamson, ¶¶ 8 and 9; A. 115). The most common device, however, is for the hospitals to meet their current operating needs by utilizing that portion of Blue Cross payments which is supposed to be funded for a depreciation reserve. In some cases, it is necessary for a hospital to use up virtually all of its depreciation reserve to meet its daily operating needs. In this way, the hospital remains "solvent" by pushing forward its bottom line operating loss to some future time when it will be unable to replace fully depreciated facilities and equipment (Supplemental Affidavit of Joseph A. Williamson, ¶ 10; A. 115).

were in effect under the Economic Stabilization Act, the hospitals and Blue Cross agreed that the contract would continue and the hospitals would be reimbursed their allowable costs as approved by Blue Cross for the prior year plus only that increase permitted by the applicable federal control ceilings (Exhibit 18; 263a).

The parties still had not been able to reach agreement on a new contract when the agreement, as amended, terminated on July 1, 1973. They continued to negotiate, however, and in January 1974, agreed to a "Summary of Principles" retroactive to the July 1, 1973 termination date as the basis for an ongoing contractual relationship (Exhibit 20; A. 269a). The Summary of Principles basically continued in effect until March 31, 1974, with some minor modifications, the previous hospital agreement as modified by the 1972 amendment. Thus, through March 31, 1974, the Delaware Valley Hospitals continued to accept reimbursement from Blue Cross in accordance with the ceilings imposed by federal economic controls.

When the parties failed to reach agreement on a new contract by March 31, 1974, the agreement, as modified and extended by the Summary of Principles, terminated and a 90 day "continuation" period commenced. By agreement, this "continuation" period was extended for an additional 31 days until July 31, 1974 (Affidavit of Bruce Taylor, ¶ 35; A. 87). Finally, on August 1, 1974, the hospitals rejected Blue Cross' attempt to extend the agreement unilaterally to August 15, 1974.

As the court below found, "[i]t was the cost reimbursement formula that led to the breakdown of negotiations . . ." (409 F. Supp. at 820; J. S. App. A7). The Delaware Valley Hospitals believed that they could not continue to absorb the losses created by the exclusions from the Blue Cross "reasonable cost reimbursement" formula. Thus,

DVHC took the position throughout the negotiations that it must have a "plus factor" sufficient to cover the unrecognized costs properly allocable to charges for Blue Cross subscriber-patients (A. 319a). Ultimately, the Pennsylvania Insurance Department recommended the inclusion of a "plus factor" as a basis for negotiations between Blue Cross and DVHC (Supplemental Affidavit of Paul I. Guest, ¶¶ 2-5; A. 102-05). However, while negotiations proceeded for a time on the assumption that a "plus factor" would be included, Blue Cross ultimately persisted in its refusal to offer DVHC anything beyond the so-called "reasonable cost reimbursement" formula.[4]

The hospitals were not fully released from the limited cost reimbursement under the Delaware Valley Agreement when the contract terminated in March, 1974 and the continuation period expired in August, 1974. Rather, on August 15, 1974, a contractual twelve-month "run-out" period commenced.[5] This resulted from the fact that the Delaware Valley Agreement provided that, following its termination as a general contract, the agreement would continue in effect on an individual basis for the remainder of any individual subscriber contracts entered into during

4. Within a few days of the passage of Act 94, the DVHC negotiators and the attorney for Blue Cross, through the efforts and in the presence of Pennsylvania's Deputy Insurance Commissioner, reached complete agreement on a package settlement which was acceptable to the Insurance Department and to the negotiators. The proposed contract was accepted by the hospitals, but was rejected by the Blue Cross Board of Directors. This proposed contract included a plus factor of 4% per year for each of three years (Supplemental Affidavit of Paul I. Guest, ¶¶ 7-10; A. 105-07; Supplemental Affidavit of Joseph A. Williamson, ¶ 15; A. 117).

5. The August 15, 1974 date for commencement of the "run-out" period was arrived at as a result of a settlement in an independent action brought by the hospitals in April, 1974 to require elimination of the cost ceiling on Blue Cross payments during the "run-out" period (Exhibit 23; A. 286a-89a).

the pendency of the hospital contract.[6] No Blue Cross subscriber was deprived of any prepaid benefits, since the "run-out" provision obligated Blue Cross to pay, and the hospitals to accept, payment upon the terms of the expired contract for services rendered any subscriber during the yet unexpired term of his or her individual subscriber contract. It was only when an individual subscriber's contract expired upon reaching its anniversary date (subscriber contracts being for one year terms) that the subscriber became liable for the total allocated costs of hospital services received and Blue Cross became obligated under any subsequent renewal of the subscriber contract only to the extent of the "indemnity benefits" provided subscribers with respect to treatment received at "non-member" hospitals (Affidavit of Bruce Taylor, ¶ 37; A. 88).

The "run out" period would have ended on August 15, 1975. Thus, when Act 94 became effective on August 2, 1975, the hospitals were limited in their right to recover full patient charges from only the last few Blue Cross subscribers still subject to the "run out" provisions. All other Blue Cross subscriber-patients were obligated to

6. Section 27 of the Delaware Valley Hospital Agreement provided as follows (Exhibit 17; A. 182a-83a):

"Obligations after Termination

"In the event this Agreement terminates for any of the reasons set forth herein, the Provider [hospital], if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the time of their admission to the Provider, and (a) who were admitted to the Provider or treated as outpatients during the ninety day period following the date of such termination; or (b) who were inpatients on the date of such termination; or (c) who were admitted to the Provider during the unexpired portion of their agreement year current at the termination, i.e., the date 90 days after the delivery of notice of termination under subsection 26.1 or the similar date under other sections."

pay the full charges associated with their hospitalization and treatment. Blue Cross itself has pointed out that, from the perspective of the hospitals, this circumstance "did not make the negotiation of a new [limited cost reimbursement] contract desirable" (Affidavit of Bruce Taylor, President of Blue Cross, ¶ 39; A. 89).

Act 94.

It was at this point that the Pennsylvania legislature stepped in. On August 2, 1975, Act 94 was signed, effective immediately. The Act reinstated the terminated contract between the Delaware Valley Hospitals and Blue Cross retroactive to the time of its original termination sixteen months earlier (March 31, 1974), and extended its term for up to thirteen months from the time of notice of any subsequent attempt to terminate. The Act provided, meanwhile, than there would be no adjustment of the reimposed contract rates unless a new contract was negotiated. The legislature thus put pressure on the Delaware Valley Hospitals to accept an offer which they had refused through more than two years of negotiations.

By its terms, Act 94 provides that no contract between a hospital plan corporation and an eligible hospital may be terminated except upon 90 days' notice and subject to prior approval of the Pennsylvania Insurance Department (Section 1(c)(1)-(2)). When the hospital or hospitals involved have more than 5% of the beds in an area served by a hospital plan corporation, as do appellants here, the Insurance Department is required to hold public hearings and is authorized further to suspend termination of that contract for a period of up to ten additional months during which time the contract sought to be terminated is to continue in full force and effect while the Insurance Department holds hearings and may supervise contract negotiations (Section 1(c)(3)-(4)).

The key to the effectiveness of Act 94 is provided in Section 1(c)(5) which allows for adjustment of the imposed rates only if a new contract is successfully negotiated, i.e., "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties." **The Act makes no provision for any adjustment in payments made under the revived and extended contracts if a new agreement is not negotiated.***

While the Act is not limited on its face to the Delaware Valley Hospitals, the retrospective provisions make it clear that the Act was aimed at the Delaware Valley situation. Thus, it is explicitly provided at Section 2(2) that the Act shall apply retroactively to the termination of any covered contract "under which subscribers [of the Hospital Plan Corporation] received prepaid benefits on or after June 30, 1974 . . . [which] contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of the act."

Proceedings Below.

On September 12, 1975, appellants filed an Amended Complaint on behalf of a class comprised of all hospitals which were or are parties to contracts covered by Act 94 and all executive officers, administrators and employees of those hospitals who would be exposed to criminal prosecution under section 6105 of Title 40 for violations of the Act. Appellants sought to have Act 94 declared unconstitutional and its enforcement preliminarily and permanently enjoined (A. 26-35).[7] The case was assigned

* Wherever boldface is used in the brief the emphasis is ours.

7. The original Complaint (A. 4-19) was filed on August 11, 1975, but was amended in accordance with a subsequent stipulation of the parties (A. 23-5).

to a three-judge court in accordance with 28 U.S.C. §§ 2281 and 2284 (A. 68), and was heard on cross motions for summary judgment (A. 69-70; 76) and supporting affidavits (A. 71-5; 77-94).

On March 2, 1976, a final opinion and order of the three-judge court was entered by District Judge Charles R. Weiner, joined by Circuit Judge Francis L. Van Dusen, denying appellants' motion for summary judgment and granting appellees' motion for summary judgment upon appellants' request for permanent injunctive relief. District Judge Alfred L. Luongo, dissenting, would have held Act 94 unconstitutional in its "retrospective effect" or at the least would have required that there be a trial of the disputed issues of fact (409 F. Supp. at 828; J. S. App. A26).

Appellants filed notice of this appeal (J. S. App. A34) and a protective appeal to the United States Court of Appeals for the Third Circuit on March 22, 1976. A separate notice of appeal to this Court was filed March 24, 1976, by the Williamsport Hospital and the Hospital Association of Pennsylvania, plaintiffs-intervenors below. This Court noted probable jurisdiction on October 4, 1976, 45 U. S. L. W. 3248, and ordered the cases to be consolidated for argument.

SUMMARY OF ARGUMENT.

This case cannot be made to fit appellees' characterization of it as a dispute between the hospital and the patient with Blue Cross as intermediary between the two (Motion To Affirm at 2). It is better characterized as one involving an abusive exercise of the legislative process on behalf of one privileged segment of the patient class at the expense of other members of that class and at the risk of destroying the private non-profit hospital as a viable social institution.

The Delaware Valley hospitals are not commercial ventures, but non-profit institutions with an historic duty of community service. That portion of their charges which Blue Cross refuses to pay is not excess profits. Rather, it includes such necessary and traditional costs of running a hospital as that of providing care to indigent patients, as well as such generally accepted costs of doing business as that of writing off bad debts (including a substantial portion attributable to patients entering the hospital as Blue Cross subscribers and exhausting their coverage before their treatment is complete). Since appellant hospitals have no profit margin within which to absorb these costs and, unlike Blue Cross, cannot appeal to a regulatory body to bail them out of cash flow difficulties, it is a simple economic fact that, unless the hospitals are to be made financially dependent on dwindling sources of private philanthrophy, they must be able to recover from patient revenues what they expend in providing patient services.

It is in recognition of this economic fact of life that the Delaware Valley Hospitals maintained through two years of unsuccessful negotiation that they could not renew their membership contract under the terms of Blue Cross' limited "reasonable cost reimbursement" formula and, upon Blue Cross' refusal to augment its payments, that

they were forced to let the Delaware Valley Agreement terminate in March of 1974.

Thus, the hospitals did not hastily obtain or frivolously assert the right to full payment which was wiped out by the Pennsylvania legislature sixteen months later when, by legislative legerdemain, Pennsylvania suddenly breathed life into the terminated contract. As the majority below recognized, Act 94 not only put the Delaware Valley Hospitals back under the contract and extended it for up to thirteen additional months, it also required the hospitals to give back full charges already collected for services rendered Blue Cross subscriber-patients and to accept instead only limited cost reimbursement.

In this respect, the Act is patently unconstitutional. Insofar as it reaches back to deprive the Delaware Valley Hospitals of rights lawfully earned and executed before its passage, it effects an unconstitutional impairment of their contract rights and an unconstitutional deprivation of their property without due process of law.

In addition, the payment formula imposed by Act 94 is confiscatory on its face. There is neither explanation nor justification for the exclusion of costs which have long been recognized as legitimate costs of doing business and are among the traditional costs of running a hospital. Thus, even if Act 94 may be characterized as rate regulation insofar as it merely extends contracts which are or are deemed to be presently in force, it is nonetheless unconstitutional since it compels the hospitals to provide service under a "rate" formula which is non-compensatory. With respect to the Delaware Valley Hospitals the non-compensatory nature of the payment formula serves to make its fully retroactive application to patient services already rendered, billed and paid for even more outrageous.

Finally, assuming *arguendo* that the payment formula imposed by Act 94 is not confiscatory as a matter of law, appellees still were not entitled to summary judgment. Appellant hospitals are entitled to a judicial hearing at which they will have the opportunity to demonstrate as a matter of fact that the rate of payment imposed by Act 94 is confiscatory.

ARGUMENT.

I. THE DUE PROCESS AND CONTRACT CLAUSES BAR THE COMMONWEALTH OF PENNSYLVANIA FROM REVIVING A TERMINATED CONTRACT WHICH RESULTS IN THE SUBSTANTIAL IMPAIRMENT OF VESTED CONTRACT RIGHTS.

After termination of the Delaware Valley Agreement in March, 1974 and subsequent continuation periods, the hospitals had the absolute right on August 15, 1974 to contract with Blue Cross subscriber-patients, as they would with any other private paying patients, for the payment of full normal charges for services received. Such contracts were made and performed by the hospitals; Blue Cross subscriber-patients were billed for full charges; and in most cases, payment was made. This was until August 2, 1975, when the legislature decreed through Act 94 that the Delaware Valley Agreement was not terminated, thus, in effect, voiding all the direct contracts between the hospitals and subscriber-patients which had followed upon its supposed termination.

Moreover, the legislature declared that the Delaware Valley Agreement and all other membership contracts presently in force could only be terminated after three months' notice, after up to six months of public hearings, after up to three months of supervised negotiations and after still another month for no particular purpose whatever (Section 1(c)(2)-(4)). It is crucial that, while the Insurance Department is to supervise these proceedings and is authorized to approve any new contract negotiated, the Department has no authority to require the negotiation of a new contract upon terms which it finds to be reasonable. Thus, after thirteen months of proceedings, Blue Cross can still refuse to agree to a contract providing

for full payment and the hospitals would not be entitled to recoup any part of the losses inflicted upon them by Act 94.

Yet, in spite of these undeniable facts, the majority below found there had been no prohibited impairment of the hospitals' contract rights nor any unconstitutional deprivation of their property. The majority's reasoning was that "[t]he public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here" (409 F. Supp. at 824; J. S. App. A15).

This is a patently incorrect legal conclusion. This Court's decisions in the cases dealing with mortgage moratorium measures for the relief of debtors during the great Depression clearly support the conclusion of the dissenting judge in the court below who recognized that a state may not effect an impairment of private contract rights which is so substantial as to constitute a taking of property without just compensation "[n]o matter how great the public need" (409 F. Supp. at 829; J. S. App. A29).

In **Louisville Joint Stock Land Bank v. Radford,** 295 U. S. 555 (1935), this Court struck down the Frazier-Lemke Act, a federal law which permitted mortgagors to redeem property at its appraised value without reference to the actual debt outstanding. The Court held that the forced surrender of property so long as any part of the debt secured thereby remained unpaid effected a taking of property without just compensation and that such a taking is constitutionally prohibited no matter how great the public need. *Id.* at 602. The Court distinguished its approval of other moratorium measures, which resulted essentially in delaying mortgagees' remedies, as resting on the "assumption that no substantive right of the mortgagee was impaired, since payment in full of the debt with interest would fully compensate him." *Id.* at 581.

Accordingly, while in **Home Building & Loan Association v. Blaisdell,** 290 U. S. 398 (1934), the Court had approved a Minnesota statute which extended the period of redemption but, by providing for the payment of interest, taxes or rent, otherwise "[did] not impair the integrity of the mortgage indebtedness," in **W. B. Worthen Co. v. Kavanaugh,** 295 U. S. 56 (1935), it struck down an Arkansas statute which extended the redemption period and permitted the mortgagor to retain possession without providing the mortgagee continued consideration for his forbearance. The Court distinguished **Worthen** from **Blaisdell** on the ground that only the Minnesota statute involved in **Blaisdell** contained restrictive conditions which safeguarded the substantive interest of the mortgagee in protecting his investment. *Id.* at 63.

In its most recent decision in this area, **El Paso v. Simmons,** 379 U. S. 497 (1965), the Court did not rely on the traditional distinction between substantive and procedural rights in permitting the state of Texas to vary, by statute, thirty year old contracts for the purchase of public lands which had permitted defaulting property owners an unlimited period of redemption. The Court stressed, however, that the power of a state thus to modify or effect the obligation of contracts is not without limit, but must be construed in harmony with the fair intent of the constitutional limitation. *Id.* at 509. The Court then held consistent with this intent, the prospective five year statutory limitation which, with respect to forfeitures occurring thereafter, ". . . allowed defaulting purchasers with a bona fide interest in their lands a reasonable time to reinstate . . . [but] does not and need not allow defaulting purchasers with a speculative interest in the discovery of minerals to remain in endless default while retaining a cloud on title." *Id.* at 515.

In **Fornaris v. Ridge Tool Company,** 423 F. 2d 563 (1st Cir.), *rev'd. on other grounds* 400 U. S. 41 (1970), the Court of Appeals for the First Circuit relied on the Due Process Clause which it found to embody "essentially the same restraints [as the Contract Clause] so far as retrospectivity is concerned," *id.* at 566-67, to hold that, the police power notwithstanding, ". . . only minor infringements of established contractual rights may be effected without just compensation." *Id.* at 567.

In **Fornaris,** the case which the dissenting judge below found to be "most nearly on point" (409 F. Supp. at 830; J. S. App. A32), the Court of Appeals held unconstitutional as applied to contracts entered into before its passage, a Puerto Rican law which prohibited a manufacturer from terminating any dealership contract unless justified by a substantial failure of performance by the dealer. The Court of Appeals stated, (423 F. 2d at 567-68):

> ". . . No amount of research by parties or amici has discovered a case suggesting that to convert a contractual relationship terminable by either party without cause into one which, short of breach by the other party, can be terminated by one of the parties only by making substantial payments and without protection for its economic interests, is not a change of great magnitude." [8]

Accord, **Superior Motors, Inc. v. Winnebago Industries, Inc.,** 359 F. Supp. 773 (D. S. C. 1973); **Globe Liquor Co. v. Four Roses Distillers Co.,** 281 A. 2d 19 (Del.), *cert. denied* 404 U. S. 873 (1971).

The legislation condemned in **Fornaris** is directly analogous to Act 94 in its application to membership contracts presently in force but entered before its passage.

8. This Court reversed **Fornaris** on the ground that the state courts should be given an opportunity to construe the retroactive impact of the statute in a manner which might avoid the constitutional question. 400 U. S. 41 (1970).

Act 94 retroactively converts these from contracts terminable upon 90 days' notice to contracts which cannot be terminated for up to thirteen months, and then only after long and burdensome proceedings. In **Fornaris,** the Court of Appeals found the unanticipated costs of terminating the dealer contracts effectively to have increased the consideration paid by the manufacturers for the contracts. So here, the cost to the hospitals of the Blue Cross contracts covered by Act 94 is increased by the amount, over the thirteen months' extension period, by which the contractual rate of payment is less than the rate which the hospitals would otherwise be able to charge for services covered by the extended contracts. And, under Act 94, this amount can never be recouped, if a new contract is not signed.

The application of Act 94 to the Delaware Valley Hospitals is far more outrageous than the situation considered by the Court of Appeals in **Fornaris.** In the instant case, the contract revived by Act 94 had been performed and terminated sixteen months' before the Act was passed.[9] The same services sought to be placed by Act 94 under the coverage of the Delaware Valley Agreement were already within the ambit of separate contracts between the hospitals and their Blue Cross subscriber-patients. The hospitals had performed their obligations under these contracts, which called for the subscriber-patients to pay full charges, had billed the subscriber-patients for full charges in accordance with these contracts and, in most cases, had been paid.

As the majority below noted (409 F. Supp. at 822; J. S. App. A12), the impact of the retroactive provisions of Act

9. While the Delaware Valley Hospitals did not receive the right to begin collecting full charges from Blue Cross subscriber-patients until the "run-out" period commenced on August 15, 1974, the contract actually was terminated six months earlier on March 31, 1974, fully sixteen months before passage of Act 94 on August 2, 1975.

94 upon the Delaware Valley Hospitals was to require them to reach into their own pockets and refund money to which they had been lawfully entitled and to accept in exchange a right to collect a lesser amount from Blue Cross under the reinstated contracts. The practical effect of Act 94 is nicely illustrated by an example drawn from appellees' Motion To Affirm (pages 7-8). There, appellees demonstrate that a hospital which could, in a hypothetical case, recover $1,350 by billing a subscriber-patient directly for services provided by the hospital would be entitled to receive only $1,080 from Blue Cross under a membership contract for these same services. Thus, the effect of Act 94 upon the hospital in this hypothetical would be to require it to take a loss of $270 which had been lawfully charged and collected for services rendered as much as a year prior to Act 94's enactment.

Whether phrased in terms of the difference between substance and remedy or simply the degree of deprivation involved, Act 94 constitutes a constitutionally intolerable impairment of private contract rights.

This is not a case like any of those relied on by the majority below. It is not analogous to labor cases such as **Steelworkers v. United States,** 361 U. S. 39 (1959). The only right limited by Section 208 of the Labor Management Relations Act, 29 U. S. C. § 178, is the employees' right to strike. There is no limit on their right to leave their present employment and sell their labor for whatever it will bring in the open market. By contrast, the hospitals here are being **compelled** to provide service and at rates which are less than those to which they would otherwise be entitled. Nor is the minimum compensatory price of labor fixed by its component costs as is that of hospital services.

Neither does this case involve the kind of *de minimis* injury involved in **Day Brite Lighting, Inc. v. Missouri,** 342

U. S. 421 (1952). That case upheld the constitutionality of a state statute giving employees the right to take time from work to vote without loss of pay. As noted by the dissenting judge below, the financial burden which the **Day Brite** statute placed upon "the net return" from a business enterprise ". . . is a far cry from the plight of these nonprofit hospitals which contend they are being forced to operate at inadequate and confiscatory levels of reimbursement" (409 F. Supp. at 830; J. S. App. A31).

Nor is this a case like **Home Building & Loan Association v. Blaisdell,** *supra,* where the realization of substantive rights is delayed but not otherwise impaired by the legislative imposition of a staying period. Even if we put aside the reinstatement of terminated contracts, Act 94 does more than merely delay the hospitals' right of termination "without penalty" (Majority Opinion, 409 F. Supp. at 824; J. S. App. A16). If no new contract is negotiated, the hospitals cannot recoup the losses resulting from their being compelled to provide extended service under the limited reimbursement formula.

Finally, this is not a case like **Fleming v. Rhoads,** 331 U. S. 100 (1947), where the effect of the challenged legislation was merely to regulate future action based upon rights which had been previously acquired but which, in the absence of legislation, would not reach fruition until some time in the future. In **Fleming** the Court permitted an injunction against future evictions prohibited by the Price Control Extension Act of July 25, 1946, 60 Stat. 665, even though the landlords had obtained lawful state judgments during the one month hiatus between the time the original rent control act had terminated and the effective date of the Extension Act.[10] By contrast, in the case of the

10. Because the inadverent lapse in regulation was so brief, it might also be said that the parties in **Fleming** had legitimate expectations that rent controls would be reenacted. No such as-

Delaware Valley Hospitals, Act 94 reaches back to invalidate rights fully implemented and presumably binding a year prior to any legislative action. *See* Note, "Impairment of Contracts—Pyramid Sales Schemes—Remaining Limitation, If Any, On the Police Power Under the Contract Clause," 1976 B. Y. U. L. Rev. 280, 290 at n. 73.

Appellees have argued that the Delaware Valley Hospitals may not claim impairment of vested contract rights since they themselves had envisioned that any new contract with Blue Cross would apply retroactively to alter charges for the period prior to the negotiation of a new contract (Motion To Affirm at 19). In making this argument, appellees confuse voluntary modification of a legal right upon terms acceptable to the holder of that right with the forced surrender of rights by legislative decree. In any case, it is highly unlikely that the hospitals would have accepted a new contract which did not permit them to retain patient charges previously collected.

It is this aspect of Act 94—a reaching back into the past to redefine the contractual relationships between private parties and to redistribute the rights and obligations among them—which is so outrageous and so offensive to constitutional standards.[11] If the mere existence of a con-

10. (Cont'd.)
sertion is permissible in the instant case. Here, we have hospitals whose only contracts with Blue Cross subscribers were contracts which required the payment of full hospital charges. The hospitals were **not** parties to contracts whereby the subscribers purchased health insurance from Blue Cross.

Moreover, these hospitals have always negotiated with Blue Cross on a voluntary, arms' length, basis and could hardly be said to have legitimate expectations that, should they refuse voluntarily to enter a contract with Blue Cross for subscriber services, they would have the very same contract imposed upon them by legislative fiat sixteen months later.

11. As was stressed repeatedly below, despite the fact that Act 94's "Declaration of Necessity" purports to be responsive to the reasonable expectations of Blue Cross subscribers, implementation

tract at some time in the past is sufficient to bind a private party to continue in that relationship or be arbitrarily thrust back into that relationship at the whim of the legislature, this must produce the kind of economic instability and personal insecurity which the Contract Clause was intended to ameliorate. *See* **Sturges v. Crowninshield,** 17 U. S. (4 Wheat.) 120, 206 (1819).

II. THE COMMONWEALTH OF PENNSYLVANIA CANNOT CONSTITUTIONALLY COMPEL A PRIVATE NON-PROFIT HOSPITAL TO RENDER SERVICE UNDER A RATE FORMULA WHICH DOES NOT PERMIT THE HOSPITAL TO RECOVER ITS FULL COSTS OF DOING BUSINESS.

In the absence of Act 94, the Delaware Valley Hospitals had, and would continue to have, the right to charge Blue Cross subscriber-patients the full allocated costs of services provided them. Act 94 severely limited this right by requiring the hospitals to accept, on behalf of Blue Cross subscriber-patients only so much of the hospitals' charges as Blue Cross chooses to recognize under its "reasonable cost reimbursement" formula. Thus, regardless of whether or not the Blue Cross formula is reasonable or compensatory or otherwise justifiable, these hospitals suffered an impairment of contract rights and a deprivation of property to the extent that their preexisting legal rights were modified and reduced by the effect of Act 94.

Appellees have argued that, except with respect to the period from the original termination of the Delaware Val-

11. (Cont'd.)
of the "run-out" provisions insured that no subscriber was deprived of prepaid benefits. Moreover, any subscriber who renewed Blue Cross coverage after July 31, 1974, did so with full knowledge that Blue Cross would pay only non-member benefits in connection with claims for services provided by the Delaware Valley Hospitals, and did so in preference to purchasing commercial insurance which has been available at all times and provides indemnity coverage for full hospital charges.

ley Agreement until passage of Act 94,[12] Act 94 may be characterized as simply a piece of prospective rate regulation (Motion To Affirm at 10). Even viewed in this most favorable of all possible lights to appellees, the arbitrary selection by the legislature of what would have to be deemed the "rate formula" embodied in the Blue Cross contracts extended by Act 94 does not meet constitutional standards. Since it is clear that even fully-regulated public utilities may not be compelled to provide service at less than a fair rate of return, **Denver Union Stock Yard Company v. United States,** 304 U. S. 470 (1938), **D. C. Transit System, Inc. v. Washington Metropolitan Area Transit Commission,** 466 F. 2d 394 (D. C. Cir), *cert. denied* 409 U. S. 1086 (1972), certainly non-profit private hospitals may not be forced by the state to provide service under a rate formula which admittedly does not reimburse them their full costs of providing hospital services.

These fundamental principles of utility law were relied upon by the Court of Appeals for the First Circuit in **Mora v. Mejias,** 223 F. 2d 814 (1st Cir. 1955), to invalidate legislation fixing a maximum wholesale price for rice which was less than the price the plaintiff-importers had paid for the rice currently in stock. Conceding the importance of the price control measure to the economic welfare of the country, *id.* at 817, the Court of Appeals nonetheless found the importers in a position "analogous to that of a public utility which is required to devote its property to the service of the public." *Id.* at 818. Accordingly, it held that

12. With respect to this period, the impairment of vested rights effected by Act 94 is rendered more oppressive by the fact that the contractual rate of payment thereby imposed is not even compensatory. However, at least insofar as Act 94 purports to undo contractual relations fully and lawfully completed as much as a year earlier, the repugnance of Act 94 to both the Contract and Due Process Clauses is independent of the reasonableness of the rate of payment under the reinstated contract.

the plaintiffs could not be compelled to sell their rice at a loss. *Ibid.*

As in **Mora,** the legislature in the instant case has fixed a retail price for a product—here, hospital services—which does not allow recovery of all the costs which have gone into producing that product. While presumably relying on the market mechanism to determine a fair retail price, the legislature as much as conceded that there is a discrepancy between a fair retail price and the one imposed by virtue of Act 94 when it provided that the contract rates revived and extended by Act 94 are, themselves, subject to revision (but only *if* a new contract is negotiated).

It is a fundamental fact that if the rates imposed under Act 94 were applied generally to all private paying patients, appellant hospitals could not remain financially solvent (Supplemental Affidavit of Joseph A. Williamson, ¶ 17, A. 117-18, and affidavit of Edward J. Armstrong, ¶ 15; A. 74-5). The majority below steadfastly avoided coming to grips with that fact.

In its first attempt at answering appellants' contention that the "rate formula" imposed by Act 94 is confiscatory, the majority below stated that "[t]he validity of such ["reasonable cost reimbursement"] clauses in Blue Cross Hospital contacts has already been upheld" in **Travelers Insurance Co. v. Blue Cross of Western Pennsylvania,** 481 F. 2d 80 (3d Cir. 1973) (409 F. Supp. at 824; J. S. App. A16).

However, **Travelers** simply is not relevant to the issues presented here. **Travelers** involved claims by a private insurer that contractual price concessions granted Blue Cross of Western Pennsylvania by its member hospitals were obtained by conduct violative of the antitrust laws. The court held that whatever "economic inducements" were offered by Blue Cross to make its contract acceptable to the hospitals did not constitute "coercion" as that term

is used to limit the protection of the insurance exemption from the antitrust laws. 481 F. 2d at 84.

Travelers does not speak to the question of whether the Blue Cross contract was fair or compensatory, far less to the question of whether a state may constitutionally compel hospitals to work under such a contract. In fact, if **Travelers** has any meaning here, it is that a private party may voluntarily choose to enter a contract which, on its face, appears to be oppressive. Thus, the fact that appellant hospitals voluntarily entered the Delaware Valley Agreement in 1971 is legally irrelevant to the question of whether the payment formula contained in that agreement and, according to appellees, adopted as a "rate formula" by the Pennsylvania legislature, is compensatory.

The majority below next declared that because Blue Cross does not require appellant hospitals to undertake those expenses such as indigent patient care and bad debts which Blue Cross refuses to recognize as "reasonable costs," "plaintiffs have failed to show that the expenses incurred by plaintiffs under Act 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement" (409 F. Supp. at 826; J. S. App. A21).

There are at least two answers to this. In the first place, it is not at all clear that Blue Cross does not indirectly require the hospitals to provide those same services which it later refuses to reimburse.

Section 23 of the 1971 contract (Exhibit 17; A. 176a) provides that each hospital "agrees to strive for accreditation by the Joint Commission on Accreditation of Hospitals" and that, if a hospital is not so accredited, Blue Cross shall have the right upon twenty days notice to terminate the agreement. The *Accreditation Manual for Hospitals* adopted by the Joint Commission in 1970 and updated in

1973 embraces in its preamble the ideal of community service and notes explicitly that "no person should be denied impartial access to treatment or accommodations which were available and medically indicated, on the basis of such considerations as . . . the nature of the source of payment for his care." In other words, the hospitals would have no right to turn away a patient or limit medically required treatment because the only source of payment for that treatment would be from extremely limited public assistance grants which would leave the great bulk of the cost to be recovered from charges to be allocated private patients. Thus, in requiring conformity to accreditation standards, Blue Cross indirectly endorses the provision of indigent care in accordance with the above principle, the observance of which in practice is said to be "a persuasive factor in the determination of a hospital's accreditation, in the same manner as are any of the standards of this [accreditation standards] volume." [13]

And Blue Cross bears a great deal of responsibility for the substantial proportion of a hospital's costs of writing off bad debts which is attributable to patients who enter the hospital as Blue Cross subscribers and then have their coverage lapse during the course of their hospitalization. While Blue Cross does reimburse the hospitals for bad debts resulting from the failure of covered Blue Cross subscribers to pay the small coinsurance charges, this amount is relatively insignificant compared to the magnitude of uncollectible accounts for services rendered patients who had originally sought service in the status of Blue Cross

13. Hospital accreditation is also dependent on an institution's employment of a competent staff of medical personnel. In this context, it is worth noting that the uncharged services provided physicians' families—which again, Blue Cross refuses to recognize as "reasonable costs"—is part of the compensation paid by the hospital to professionals who are able to command much higher base salaries than those paid by most hospitals.

subscribers (Supplemental Affidavit of Joseph A. Williamson, ¶ 4; A. 113).

More fundamentally, it is strange indeed for the majority below to suggest, as a necessary condition to finding the Blue Cross reimbursement formula compensatory, that the hospitals could simply abandon costs necessary to the performance of their historic role as social and charitable institutions. A review of the historic development of the hospital as a social institution specifically refutes Blue Cross' contention that non-profit charitable institutions should not expect to recover from paying patients the costs of their charitable services (Motion To Affirm at 17, n. 14). While the European hospital was historically an institution endowed by the rich for the treatment of the poor, *see* H. Burdett, HOSPITALS AND ASYLUMS OF THE WORLD (1893) Volume III, American hospitals from the start tempered the charitable ideal with the principle that it was important to a patient's self-respect that he or she pay whatever he or she is able to pay. Accordingly, hospital charges in this country have always been variable, graded to the individual patient's income level. M. Risley, THE HOUSE OF HEALING (1961) at 226. *See generally* E. Churchill, "The Development of the Hospital" in the HOSPITAL IN CONTEMPORARY SOCIETY (N. Faxon, Ed., 1946).

Just such a glib solution as is proposed by the majority below was rejected by the First Circuit in **Mora,** *supra*. There, the Court of Appeals looked to the practical importance of rice in the Puerto Rican diet to hold that "application of the principle that the members of the industry could escape loss by withdrawing from the business of importing rice is not an honest answer to the question at issue." 223 F. 2d at 817.

The position of the majority below is quite inconsistent given that initially it justified Act 94 on the grounds

that hospitals are institutions affected with the public interest and that the presumed unavailability of hospital services is a crisis which would justify otherwise unconstitutional legislative intervention. Moreover, the majority's position is in conflict with the weight of judicial authority which, even in the regulatory field, has held that included among the legitimate costs of doing business are those associated with writing off bad debts, *see* 73 C. J. S., Public Utilities § 25 at 1041, and making charitable contributions which affect the utility's good will in the community, *see Annot.*, 59 ALR 3d 941 (1974).[14]

Ultimately, the majority seemed to give up its attempt to justify the Blue Cross reimbursement formula as nonconfiscatory and decided that it simply need not deal with this question which is "for the legislative process as distinguished from judicial inquiry" (409 F. Supp. at 825; J. S. App. A17). The majority further declared that Act 94 constituted a delegation of this question by the legislature to the Insurance Department. *Ibid.*

14. Blue Cross relies on the 1953 "Principles of Payment for Hospital Care" of the American Hospital Association (Exhibit 35; A. 417a-40a) as establishing a basis for the exclusion from the Blue Cross reasonable cost reimbursement formula (See Supplemental Affidavit of Bruce Taylor, ¶¶ 60-62; A. 120-21). While the AHA still maintains for accounting purposes that the costs of indigent care and bad debts should be considered as deductions from revenue rather than expenses, it insists that every purchaser of health care must pay a proportionate share of these costs. Thus, its more recent "Statement on the Financial Requirements of Health Care Institutions and Services" (Chicago, 1969) states (at 14):

> "Even with agreement as to the method of payment, negotiations could result in one or two contracting agencies paying less than their appropriate share because of their failure to accept all of the necessary elements of financial requirements. **Any negotiation which permits one or more contracting agencies to assume a lesser responsibility does not alter the total financial requirements of the Health Care Institution, rather it forces other payers to make up the deficiency.** It is for this reason that health care institutions should not permit any contracting agencies to pay less than their appropriate share."

However, the Insurance Department has no duty or authority under Act 94 to assure that payment under the extended or reinstated contracts is reasonable or compensatory. More importantly, the Insurance Department has no power independently to order any retroactive adjustment of payments. Rather, the Act provides only that, *if* a new contract is negotiated and approved by the Insurance Department, its terms shall apply retroactively to the date of termination of any prior agreement. Thus, even if the Insurance Department did find the contracts imposed by Act 94 to be confiscatory,[15] the most it could do would be not to exercise to the fullest its authority under Act 94 to suspend for up to thirteen months the hospital's right of termination. In other words, the Insurance Department has limited power under Act 94 to exacerbate the confiscatory impact of the imposed contracts, but no power to relieve it.

Nor does the Act itself evidence any considered or rational basis for the exclusion of identifiable items of expense from the reimbursement formula. There is no evidence that the Pennsylvania legislature ever considered underlying conditions in the health care industry. As the dissent below suggests, Act 94 was "an unfortunately hasty reaction" by the legislature to the complex problem spawned by the Blue Cross contract dispute (409 F. Supp. at 831; J. S. App. A33).[16]

15. The fact that the Pennsylvania Insurance Department was willing to approve a contract which included a 4% plus factor (Supplemental Affidavit of Paul I. Guest, ¶¶ 7-10; A. 100-07), suggests that it might well have found the 1971 contract to be noncompensatory.

16. Blue Cross, itself, has conceded in other contexts that it is hardly appropriate for the legislature to rely upon Blue Cross to formulate appropriate hospital rate schedules. Included in the statement made by Blue Cross' President, Bruce Taylor, in public

The statutory provisions, themselves, suggest that the legislature was aware that there was a discrepancy between the payment formula imposed by virtue of Act 94—which, if it had been the product of negotiations four years' earlier, had been resisted ever since by the hospitals as a basis for any new contract—and a formula which would reflect the present cost and value of hospital services. The legislature specifically provided that the rates imposed by Act 94 were not necessarily final rates. Rather, if a new contract were negotiated by the hospitals and Blue Cross its terms would be made retroactive to the date of termination of the preceding contract, thus recreating

16. (Cont'd.)
hearings before the Insurance Department on March 17, 1971, was the following (Exhibit 44; A. 455a-56a):

> "Second, Blue Cross regulation of hospital cost raises serious internal problems. Hospitals vary infinitely and general standards applicable to all cannot be fixed fairly. Differences in plant, in the type of cases, type of medical practice and many other factors affect their cost. To consider these multiple factors properly would require a major expansion of the Blue Cross staff.
>
> "Moreover, Blue Cross, even with an expanded staff, is not peculiarly fit for this decisional process. It has no expertise in many of these areas. Moreover, as the payor, Blue Cross decisions could be biased by its interest in reducing its own payments.
>
> "Third, decisions on most areas of hospital cost control will have profound influence on the entire health care delivery system. To suggest that such decisions should be exclusively in the hands of a single purchaser of health care is clearly foolhardy. Blue Cross personnel can claim no infallibility in this field, nor even special training where medical practice or hospital procedures are involved. Obviously, and without false modesty, this role should not be exclusively ours.
>
> "Fourth, legal authority is required to produce involuntary changes in the health care system as it exists today. . . .
>
> "Such uniformity can only come through governmental supervision based on law, and not the indirect pressure of changing Insurance Commissioners through a variety of Blue Cross entities."

the situation which could have existed had Act 94 never been passed. However, there is no rational reason why the rate formula imposed by virtue of Act 94 should constitute reasonable final rates for the effective period of the Act just because the hospitals fail to negotiate a new membership contract. Thus, the contingent provision for revising rates payable under Act 94 serves only to underline the arbitrariness of attempting to pluck a "rate formula" out of a private contract negotiated four years earlier.

Even if the majority were correct that the selection of a rate formula was a question originally for the legislative process, it is clear that where the legislature has failed to propose any rational or considered basis for its selection of a rate formula, it is for the courts to strike down such an arbitrary formula as improper. **Patterson Drug Co. v. Kingery,** 305 F. Supp. 821, 827 (W. D. Va. 1969); *cf.* **Nebbia v. New York,** 291 U. S. 502, 516 (1934). As demonstrated above, the formula incorporated by Act 94 is arbitrary and unconstitutional in that admittedly it requires the hospitals to provide service at rates which deny them recovery of their traditional and appropriate costs.

III. APPELLANTS ARE ENTITLED AT THE VERY LEAST TO A FACTUAL HEARING TO DETERMINE WHETHER THE CONTRACT RATES IMPOSED BY ACT 94 ARE CONFISCATORY.

Even if we assume *arguendo* that Act 94 is not unconstitutional on its face, it was nonetheless improper for the court below to have granted summary judgment to defendant-appellees. At the very least, appellant hospitals are entitled to a full hearing at which they will be given an opportunity to prove the confiscatory effect of the reimbursement formula as applied to individual fact situations. As Judge Luongo pointed out in his dissent, even if appellants' affidavits are not conclusive, they at

least raise material issues of fact sufficient to withstand appellees' motion for summary judgment (Dissenting Opinion, 409 F. Supp. at 829, n. 1; J. S. App. A29).

The majority opinion seems to have been written under the misapprehension, fostered by Blue Cross, that the hospitals are regulated entities. For example, at paragraph 57 of his Affidavit, the President of Blue Cross states (A. 94):

> "57. In sum, the Pennsylvania Plans, lacking direct governmental authority to limit hospital cost, have traditionally negotiated cost limitations and quality controls into their contracts with Member Hospitals. These controls are the product of collective bargaining and represent a substantial value for Subscribers. The Pennsylvania Legislature recognizes the success that the Plans have achieved in this voluntary process and encourage this form of development by only indirectly regulating hospital rates, that is, through Insurance Department approval of hospital contracts. However, if this bargaining process is no longer viable, hospital rate setting regulation may be required."

While it is true that the Insurance Department has authority to approve transactions of hospital plan corporations including their contracts with member hospital, 40 Pa. C. S. § 6124, it is only to the extent that a hospital joins in the submission of such a contract for the approval of the Insurance Department that it is subject to any form of regulation by the Insurance Department or any other regulatory or administrative body.

Nonetheless, the majority below distinguished the decision in **Fornaris v. Ridge Tool Co.,** *supra,* on the ground that "their [the hospitals'] expectations as a regulated industry are different from those of the commercial manufacturers in **Fornaris**" (409 F. Supp. at 824; J. S. App. A16). Moreover, the majority analogized the effect of Act 94 which requires appellants to refund subscriber payments lawfully due and remitted prior to the enactment of Act 94 to "remedial measures in other regulatory statutes" as, for example, when carriers are required to "refund, with interest, increased rates found to be not justified" (409 F. Supp. at 825, n. 12 and accompanying text; J. S. App. A19).

What is most bizarre about this theory is that, if the hospitals were regulated in fact, they would have been afforded those fundamentals of due process—both procedural and substantive—which they have been denied here. One has only to look at the various bills which have been proposed by the Pennsylvania legislature for the regulation of the health care industry to see that, if appellant hospitals were in fact regulated, they would have been guaranteed an opportunity for prior hearing upon the reasonableness of the proposed rates and, of course, with the right to judicial review (See proposed bills collected at Exhibits 33 A-E; A. 334a-416a).

Implicit in the majority's assumption of regulation is the belief that there is some regulatory body required to take into consideration the interests of the regulated party and from which that party may seek relief from an onerous exactment. Thus, for example, the majority assumed that the Insurance Department was authorized to consider and adjust the adequacy of payment under the reinstated contracts. However, while Act 94 does provide for hearings before the Insurance Department, the right to be heard means little since, as noted above, the Insurance Department has no authority to alter the rate of reimbursement under the Blue Cross contract or to require Blue Cross to agree to a compensatory contract in the future.

The legislature, on the other hand, never bothered to provide the hospitals an opportunity to comment on the reasonableness of the Blue Cross reimbursement formula before it was imposed upon them by virtue of Act 94.

In effect, then, as a result of the scheme embodied in Act 94, the hospitals have been deprived of the right to protect their own interests by voluntary arm's length negotiations, without being accorded the due process attached to regulatory proceedings. Under these circumstances, they cannot, in addition, be deprived of the opportunity to a judicial hearing upon their claim that the contract rates imposed by Act 94 are confiscatory and unconstitutional as applied to their individual factual situations.

CONCLUSION.

For the reasons set forth above, the judgment of the United States District Court for the Eastern District of Pennsylvania should be reversed with directions to enter judgment and injunctive relief for appellants or, at the very least, to grant appellants a hearing on their contention that the rates imposed by Act 94 are confiscatory as applied to their individual factual situations.

Respectfully submitted,

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ADDENDUM.

Act 94 of the 1975 Session of the Pennsylvania Legislature (Act of August 2, 1975, P. L. 293, amending Section 6124 of Title 40 of the Pennsylvania Consolidated Statutes), provides as follows:

Section 1.

Section 6124 of Title 40, act of November 25, 1970 (P. L. 707, No. 230), known as the Pennsylvania Consolidated Statutes, added November 15, 1972 (P. L. 1063, No. 271), is amended by adding a subsection to read:

§ 6124. Rates and contracts

. . .

(c) Maintenance of contractual relationships.—

(1) Declaration of necessity.—It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be

subject to prior approval by the department as provided in this subsection.

(2) **Notification period.**—No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.

(3) **Hearing period.**—Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) **Negotiation period.**—If the department recommends terms for continuation of the contract, the

hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of the hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) **Retroactivity.**—Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2.

The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received

prepaid benefits on or after June 30, 1974 if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C. S. Chap. 61 (relating to hospital plan corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3.

This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

Approved the 2nd day of Aug. A.D. 1975.